M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

10th January 2019 REF: 8714

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Avon & Wiltshire Mental Health Partnership NHS Trust**
1	**CORONER** I am Maria Eileen Voisin Senior Coroner for the **Area of Avon**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 03/01/2018 I commenced an investigation into the death of Christopher Michael SEAL. The investigation concluded at the end of the inquest. The conclusion of the inquest was Christopher Seal died on 30th November 2017 at the playing fields, Bath Spa University, Newton St Loe, Bath. He had placed a rope around his neck and was found suspended from the rugby posts, he had intended to take his own life.
4	**CIRCUMSTANCES OF THE DEATH** Chris's death was due to suicide. However in the 5 days leading up to his death he was under the care of the mental health team. On 26th and 27th November Chris had been assessed as high risk and the plan was to assess him in the community as he indicated he was willing to engage. On 27th and 28th November he failed to respond to calls and disengaged from the service. On 29th November he cut his wrist and was assessed as high risk again by the mental health liaison team at the hospital and the plan remained the same, there was an underestimation of his condition at this assessment. Chris failed to be at home for the assessment immediately following his discharge. A welfare call to the police was made but the important information from the police following the welfare check was not relayed to the team or recorded in the records as it should have been. The cold call to Chris's property on 30th November resulted in the only action of leaving a letter with another appointment; there was no escalation as suggested in the "no response and police welfare check requests procedure" which is only a guide for patients in primary care as no policy exists. Finally there was no contact made with the family during 29th or 30th due to a poorly completed information sharing form.

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5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The information sharing form – in this case it was not explicit as to whom information could be shared with hence the family were not informed or contacted; is there an issue with the form itself to make this clearer for clinicians to be more explicit or is there a training issue for the staff involved with completing this form? 2. On the RIO records system I was advised that it put the first information sharing form as the most recent when it wasn't, in this case there was a more recent form, this misled the staff, although both forms were clearly completed and on the RIO system – is this a technical matter with IT or is this a training matter for the staff using the system? 3. There were no next of kin details recorded on RIO – I was told that you use The National Spine to automatically populate this information however the next of kin details were on the hospital records for the A&E attendance and I was told that they use The National Spine. Is this system being used properly? 4. The demographics page in RIO – in this case it was incomplete and I was told it often is – is this training issue for the staff or again a technical matter with the RIO system? 5. I was told that there is no "no response policy" for those in primary care; that the policy which exists is for secondary or tertiary care and is therefore not applicable to the service users or staff in primary care. This would also raise the question of training 6. I was told that there is no "welfare check policy" for those in primary care; that the policy which exists is for secondary or tertiary care and is therefore not applicable to the service users or staff in primary care. I was told that Avon and Somerset Constabulary are in the process of writing a "welfare check policy" and it may be beneficial for there to be liaison with the police forces in the AWP area to ensure that any new policy that you consider is appropriate is in line with their expectations as to what a police officer can and will do following such a call. This would also raise the question of training. 7. RIO entries generally – I was told that there is an expectation that staff are expected to make their entry onto the RIO system within either 72 hrs. or 24hrs. Is this in line with what professional bodies expect and should it be? 8. The intensive service switchboard – is there an issue in relation to the training of staff and their ability to react to protecting life? I was told they do not have ability to call 999 but that they advise the service user to make the call, is that appropriate? 9. Contact with service user – I was told that the preferred method is verbal contact and the only other means is a text message with this being care planned. In this changing world of communication should other care planned options be considered such as email or messaging?

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th March 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the chief coroner and to the following interested persons: [redacted] - father of deceased [redacted] – mother of deceased Royal United Hospital, Bath I am also under a duty to send the chief coroner a copy of your response. The chief coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the chief coroner.
9	10/01/2019 Signature_____ M E Voisin Senior Coroner **Area of Avon**